21st MDG HEALTH MAINTENANCE EVALUATION: PETERSON CLINIC

2 Months

Patient	Date Time	Time arrived	Age	Provider

Welcome to the Peterson AFB Clinic. We are transitioning to a new electronic medical records system that will allow us to provide your child better health care (notes will be legible, your child's medical record wont be "lost", etc.) Please bear with us while we proceed with this transition.

The electronic medical record system allows us to be very thorough, but it requires a bit more work on the part of the parents. These forms are available on our clinic's webpage if you'd like to complete them before future visits. Eventually we will have electronic records only without any paper charts. This cutting-edge system is Dept of Defense wide, so you may already have experience with this at other clinics. If you feel we could be gathering your medical information in a better way, please feel free to let us know.

Parents, please answer all questions below and on the reverse page	**Is this your first visit to our clinic?**
Who brought the patient today? (mom, dad, guardian, etc.)	**Would you like to speak with someone about postpartum depression?**
Is your child currently taking any medications? **□ Vitamins □ Other**	**Is there a family history of any of the following diseases? (Please list which family members affected)** **□ cancer □ alcoholism □ birth defects** **□ mental illness (not retardation) □ genetic disease** **□ deafness before age five □ sudden infant death syndrome**
Allergies to medicines, latex, foods or anything else? **What happened exactly with this allergic reaction?**	
Who cares for your child during the day? (home, extended family, daycare, etc)	

DIET

BREAST MILK	FORMULA
Feedings per day: _____	**Feedings per day: _____**
Minutes per breast:_____	**Ounces per feeding: _____**
	Brand: _____

DEVELOPMENT *(Check all that apply to your child)*

□ Lifts the head and chest off a surface	**□ Looks past midline**	**□ Coos** **□ Attentive to voices** **□ Has a social smile**	**□ failure to thrive** **□ difficulty feeding infant** **□ poor growth**

REMARKS *(Explain any concerns from above)*

Review of Systems ◦ ◦ ◦ ◦ ◦		***Yes (please specify)***	***No***
Fever ? Please circle how you checked it:	***Highest*** **Temperature:**		
Cough?			
Runny nose?			
Rash?			
Stomach ache?			
Diarrhea?			
Hard stools?			

Functional Assessment (needs to be completed at <u>first</u> visit to clinic and then annually)	***Yes (please specify)***	***No***
Does your child receive any routine therapies (speech therapy, occupational therapy, physical therapy)		
Does your child have any speech, language or communication problems?		
Has your child gained or lost 10 pounds over 3 months without changes in diet?		
Does your child have difficulty with swallowing or frequent chocking?		
Does your child have any hearing loss or communication problems?		
Does your child have any loss of vision, double vision, lazy eye or other visual/ eye problems?		
Is your child in a verbally, physically or sexually abusive situation?		
Is your child in danger at home or school?		
If applicable for your child's age, does your child have religious or cultural practices that we should be aware of?		
If applicable for your child's age, does your child have barriers that prevent them from learning?		
What is your family's primary language?		

REMARKS *(Explain any "YES" answers and concerns from above)*